Tech Waiver PDN/EPSDT Q&A

1	For individuals under the age of 21 with the CCC+ Waiver, currently receiving EPSDT services, will that continue beyond the 90-day continuity of care period?	Yes, if the PDN agency submits the DMAS 62 for EPSDT PDN Service Authorizations to the CCC Plus plan and the health plan approves the EPSDT PDN based on medical necessity. The care coordinator will also work with members and providers to develop an individual service plan that will include services and supports beyond the 90-day continuity of care period. The individual service plan will be developed based on the individual's service and support needs.
2	How will individuals under the age of 21 with CCC+ Waiver qualify for PDN services?	To be eligible for PDN services through the CCC+ waiver, a participant must meet the criteria identified on either the DMAS 108 or 109 as appropriate.
3	Will individuals under the age of 21 on the CCC+ Waiver be scored based off of Tech Waiver requirements, or will they be scored off of the DMAS 62?	Individuals receiving private duty nursing through the CCC+ waiver must meet the criteria identified on the 109. The DMAS 62 is used for EPSDT PDN SA and is submitted to DMAS MSU while member is in FFS.
4	Will the Health Plans be held to the DMAS 62 scoring for individuals under the age of 21 who do not qualify for PDN based on Tech Waiver requirements?	Yes, CCC Plus health plans will use the DMAS 62 scoring for EPSDT PDN for individuals < 21 who do not meet the Tech waiver requirements.
5	How will children qualify for the CCC+ Waiver access EPSDT?	For individuals participating in CCC+, the care coordinator will work with the individual to determine if EPSDT services are needed. Service authorizations will be sent to the MCO. For individuals receiving services through FFS, authorizations for EPSDT services will be submitted electronically to KePRO.
6	Annual Level of Care Reviews are currently processed and completed through the Virginia Medicaid Portal. How will providers be notified they are due (we currently receive an email from DMAS)? Where will they be completed? Currently the reviews are completed on the portal.	Health Plans will complete the Annual LOC reviews. During the first month of each regional rollout, the plans will rely on the providers to send them the LOC review. Provider training was done last week on specific processes and is now posted. This is the link and the name of the PowerPoint presentation. http://www.dmas.virginia.gov/Content_pgs/ltc-home.aspx

		FFS Provider Changes to Annual LOC with Launch of CCC Plus
7	Nursing hours is in an IEP have traditionally been subtracted from total hours allocated. For example, if a member has 84 hours approved per week and 36 of those hours were covered by schools the member does not receive an additional 36 hours at home but receives 48 hours at home. Will this be the same practice?	If the nursing hours are covered under school services which are carved out of CCC Plus Program, then only the hours provided in the home would be authorized by the MCO. The MCOs will have the flexibility to authorize more hours as deemed medically necessary.
8	What is the resource for MCOs and Providers to obtain required paperwork from the screening team UAI, DMAS 96, 97, 108 & 109? (already received a call from an MCO asking for this paperwork and the member has actually chosen another MCO)	For individuals currently in TW, DMAS will be providing a copy of the screening to the MCO. For any new individuals, the screening team will send the screening packet to the MCO. The MCO Care Coordinator will provide a copy to the service provider who will maintain a copy in the member's medical record.
9	How long is the length of authorizations?	Refer to chart for each plan's authorization period. This will vary from 6 months to one year.
10	Will there be a specific reauthorization form required? (Traditionally there has not been a specific form for Tech Waiver).	Refer to chart for each plan's required documentation.
11	For transfer of care and for Initiation of Care when will the DMAS 116 and the signed POT be required to be at the MCO.	Tech Waiver manual requires the DMAS 116 and 485 (POT) be sent within 48 hours of beginning services. A signed copy of 485 is sent immediately upon receipt by provider and provider may not bill until signed copy is on file.
12	Regarding the transition of current authorizations-will the MCOs generate their own authorization with a new auth number that begins 8/1/17 or will the MCOs use the authorization number on the existing authorization?	Current authorizations are honored for the 90 day continuity of care period, unless the current authorization ends during the 90 days. Each MCO will generate a new authorization from their systems based on the information received from DMAS. The DMAS authorization number cannot be used once the member transfers to CCC Plus.
13	Will MCOs cover doctor visits as Medicaid previously did?	Yes. Medical care is covered under CCC Plus. If an individual is being seen by a doctor not in the MCO network, the MCO will cover the doctor visits for the first 90 days of enrollment, after which, the member will need to change to a network provider if the MD still chooses not to contract with the MCO. Some MCOs will initiate a single case agreement with some providers. Care coordinators will assist with this process.
14	Will MCOs cover services if family travels-Medicaid currently does on a case by case basis.	This varies among specific services. Generally, any special or extenuating circumstances will be reviewed and considered on a case by case basis. Providers should work with MCO Care

		Coordinator regarding these types of requests.
15	Some families have not received their letters yet, what should they do?	Families can contact the CCC Plus Helpline to determine if they are being placed into CCC Plus for the upcoming region. Providers can send specific case examples to DMAS for further investigation as needed.
16	If school hours are in the IEP does the billing have to be exact to the minute or do we round in 15 minute increments?	If the services are being covered by the schools, they are “carved out” and existing FFS rules continue to apply.
17	Now that all waivers have 480 hours of respite will it renew on the fiscal year or the calendar year?	Respite for all CCC Plus Waiver individuals is now 480 hours per FISCAL year.